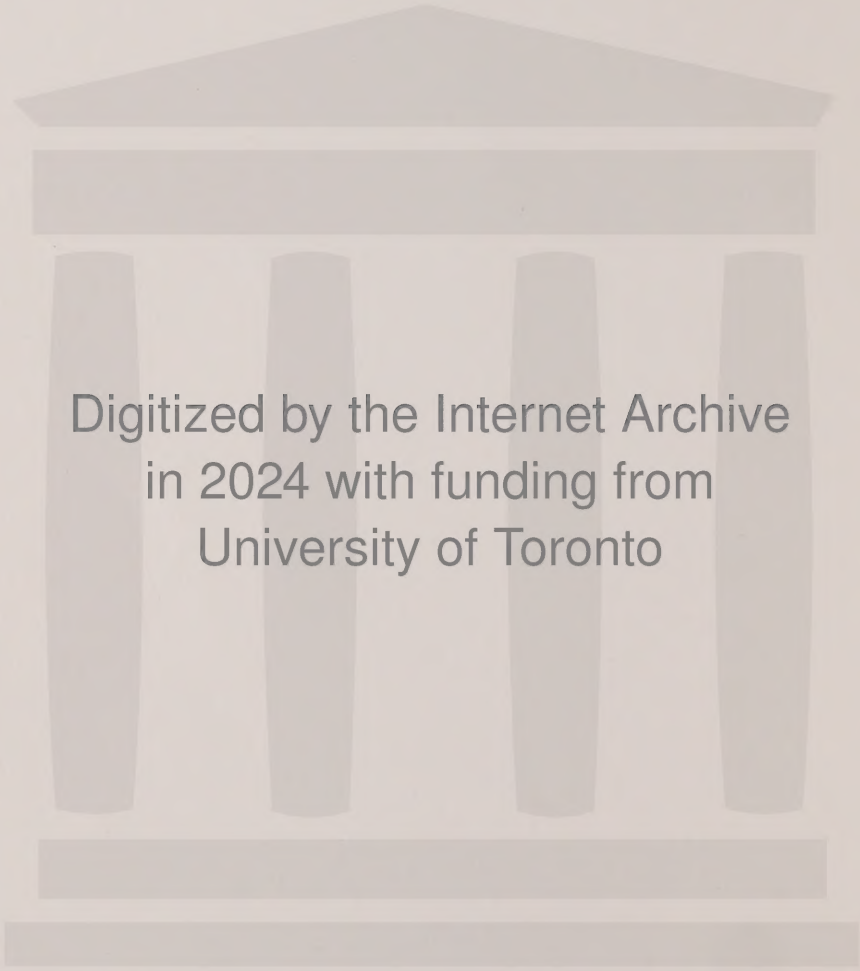
REPORT ON THERAPEUTIC ABORTION SERVICES IN ONTARIO

A STUDY COMMISSIONED BY THE MINISTRY OF HEALTH

MARION POWELL

JANUARY 27, 1987

TORONTO, ONTARIO



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Thanks are expressed to the many colleagues, in hospitals, public health units and family planning clinics throughout the province who attended meetings and freely discussed the issues relating to access to abortion in Ontario. The questions raised about local problems were answered at these meetings. Many communities which were not visited provided valuable information through long distance telephone calls. Because of the contribution of all of these individuals, as well as staff at clinics, this report was made possible.

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SUMMARY

The 1970 legalization of abortion resulted in the transfer of the procedure from the back alleys to the safety of hospitals in a progressive life saving move. Now sixteen years later, abortion has become more of a social issue than a medical challenge.

With mounting pressure from various groups in Ontario, the Ministry of Health, in June of 1986, commissioned Dr. Marion Powell to review access to therapeutic abortion services in Ontario public hospitals. The problem was studied in terms of the components of the referral process. The terms of reference for the project specifically required identification of:

- the demand for and availability of services by geographic area
- programme components that women require
- referral patterns and scheduling process
- operation of the therapeutic abortion committees

Field visits were made to 34 hospitals and an additional 14 hospitals were contacted by phone. Visits were also made to 16 public health units and phone contact was made with the remaining 27. In addition, Planned Parenthood groups and freestanding clinics were visited.

Previous studies of abortion services in Canada had found significant regional disparities in the availability of therapeutic abortion committees and abortion services. Similarly in Ontario, abortion services were much less available in smaller centres. Of particular concern in the province was the high proportion of second trimester abortions with the concomitant increase in complications as a function of gestational age and type of procedure used.

The literature, as well as Ontario data, indicate that failed contraception is a primary factor in the need for abortions. Women requesting repeat abortions are found to be at higher risk of becoming pregnant because of factors related to age and fertility.

The declining rate of unwanted pregnancy among teenagers suggests the effectiveness of government funded family planning programmes in public health units in Ontario.

In over 50 percent of Ontario counties, the majority of women obtaining abortions had the procedure outside their place of residence. In addition, a minimum of 5000 Ontario women obtain abortions each year in freestanding clinics in Canada and the United States.

When analysis was made of the abortion process, it was found that the system does not provide timely and optimal support to women in need of abortion services. Difficulties were identified at each step from the time the woman suspects pregnancy to the completion of the abortion procedure. The entire process was found to be protracted with women requiring three to seven contacts with health professionals before the actual procedure could be performed. This places an increased burden on those women who must travel out of town to obtain their abortions.

The problems and issues identified by the study:

availability of physicians willing to make referrals for abortion,

availability of counselling both pre and post abortion,

availability of hospitals with therapeutic abortion committees,

perception by members of therapeutic abortion committees that these committees serve no useful purpose,

restrictive criteria used by some hospitals,

decreasing availability of gynaecologists and anaesthetists willing to perform the procedure,

availability of operating room time for the procedure,

inadequate use of procedures which are recognized as reducing complications from abortions,

charges to patients for non-insured services such as letters of referral and presentation to the therapeutic abortion committee,

negative attitudes in the community,

punitive attitudes among some health professionals towards women seeking abortions.

The current model for the provision of abortion services stresses an institutional approach to care that can be provided in less resource intensive settings. Many hospitals have indicated an interest in enhancing counselling services and developing innovative approaches to providing abortion services.

Abortion procedures in general have not kept pace with the trend to provide services of a similar level of technical difficulty, entirely on an out-patient basis. Similarly, there is overemphasis on the provision of services by gynaecologists and anaesthetists when trained general practitioners could be providing these services.

There is inadequate use of techniques which have been widely recognized in other provinces and countries for reducing the incidence of post abortion complications.

RECOMMENDATIONS

The Ministry should consider proposals from hospitals for a range of innovative abortion services such as:

multi-purpose women's clinics,

regional centres affiliated with but not necessarily located in a hospital,

inter-hospital counselling and referral centres,

satellite medical services which travel to smaller communities.

Exisiting abortion services, particularly in small communities should be enhanced and encouraged.

The Ministry should develop alternate means (such as sessional fees) to reimburse physicians for abortion related services, so as to remove any disincentives to providing all the services required: including abortion counselling, preparing letters of referral, presenting cases to the therapeutic abortion committee, pre-abortion dilatation procedures.

Hospitals should encourage general practitioners to perform abortion procedures and provide opportunities for training.

The Ministry should increase funding to public health units to expand family planning programmes, clinics, sex education, and counselling.

Recognition should be given to the need for financial assistance to cover transportation and accommodation costs for women who must leave their communities to obtain abortion services.

The Ministry of Health should fund research projects examining alternate abortion techniques.

The Ministry of Health should provide funding for research into the high incidence of second trimester abortions.

INTRODUCTION

In June of 1986, the Ministry of Health commissioned Dr. Marion Powell to review access to therapeutic abortion services in Ontario. The terms of reference for the review are provided in Appendix I.

It should be noted that there is no specific definition or objective standard by which to judge accessibility. Although there are a number of abortions being performed in the Province, this alone is not an adequate measure of access. Women must locate a referral source, and are frequently faced with delays and obstacles such as: repeated phone calls to arrange appointments, several consultations with physicians, travel outside the community, and the payment of administrative fees in order to obtain the procedure. One study found for example, that the burden of travel is an important determinant of whether a woman obtains an abortion (Jaffe et al., 1981).

Since difficulties in obtaining an abortion are thus part of the access question, the problem was studied in terms of the components of the referral process and the obstacles to obtaining abortion services. The terms of reference for the project specifically required identification of:

- the demand for and availability of services by geographic area
- programme components that women require
- referral patterns and scheduling process
- operation of the Therapeutic Abortion Committees

A second phase of the project, as noted in the terms of reference, is to assess the need for expanded family planning services.

It was not the intent of the study to debate the pros and cons of providing abortion services, rather abortion was viewed as a legally defined health service whose availability was under review. The approach could be summed up by the writings of Jaffe et al. (1981) which stated:

> "In a society that values equity...it is a matter of public concern whether abortions are publicly available to all women who need and want them, in all parts of the country, and in all socioeconomic and age groups." (p. 1)

In the pages which follow, an overview of abortion services is presented, beginning with a summary of relevant legislation and previous studies of service provision. Statistical data of abortions in Ontario are followed by a detailed description of each phase of the abortion referral process and the problems encountered.

METHODOLOGY

Data for this study were obtained by surveying the literature, and consulting available reports and statistics concerning abortion from Statistics Canada, the Ontario Ministry of Health, individual hospital and public health units.

Field visits were made to 34 hospitals and an additional 14 hospitals were contacted by phone. The hospitals visited included:

a sampling of hospitals in both urban and rural areas throughout the Province,

all university centres with medical schools,

areas known to have problems concerning some aspect of abortion services,

hospitals that do high numbers of abortions (ie. greater than 1000 per year).

Interviews were conducted with: hospital administrators, medical directors, members of the Therapeutic Abortion Committees, Chiefs of Obstetrics and Gynaecology, Gynaecologists performing abortions, Directors of Ambulatory Care, OR Supervisors, representatives of Social Services, and the public health units.

Visits were made to 16 of the public health units and information was obtained from the remaining 27 by telephone. Meetings were held with Medical Officers of Health, Directors of Nursing, Family Planning Supervisors, Family Planning Coordinators as well as clinic personnel.

Other contacts included: the Ontario Medical Association, Ontario Hospital Association, and Parenthood Groups in five cities in Ontario. American sources were: the Guttmaker Institute, Planned Parenthood Federation of America, and two American freestanding abortion clinics.

Models of service provision were reviewed in Manitoba, Alberta and Quebec and the two freestanding abortion clinics in Toronto were visited.

LITERATURE REVIEW

CANADIAN LAW CONCERNING ABORTION AND CONTRACEPTION

Canada's Criminal Code, which dates back to 1892, contains provision for the life imprisonment of individuals who "procure the miscarriage of a female person" and two years imprisonment for a woman who procures an abortion. Amendments to the Criminal Code (Revised Statutes of Canada 1970, Chapter c-34, Section 251), provide certain exceptions under which abortion can be performed. These conditions require that:

> the abortion be performed in a hospital accredited by the Canadian Council on Hospital Accreditation in which diagnostic services and medical, surgical, and obstetrical treatment are provided or in a hospital approved by the Minister of Health of the Province
>
> prior to the abortion, the majority of members of the hospital therapeutic abortion committee (comprised of at least three qualified medical practitioners) certified in writing that the continuation of the pregnancy was likely to endanger the life or health of the female person
>
> the abortion be performed by a qualified medical practitioner who is not a member of the hospital's therapeutic abortion committee.

The law does not require hospitals to have therapeutic abortion committees, but without such committee approval, an abortion is an indictable offense. In addition, there are provincial statutes which limit the circumstances under which hospitals can establish therapeutic abortion committees. In Ontario, the committees can only to be established in hospitals where there are ten or more members on the active medical staff (Regulation 729 adopted in 1974 under the Public Hospitals Act).

It is interesting to note that up until 1969, contraception was also illegal in Canada according to section 251 of the Criminal Code and the distribution of contraceptive methods or the provision of information on family planning were indictable offenses. While the law was widely disregarded, there was no government financial support for family planning programmes until the law was changed. The Ontario government did not fund public family planning programmes until 1975.

PREVIOUS STUDIES OF ABORTION SERVICES

In 1975, the Privy Council appointed a Committee on the Operation of the Abortion Law to determine whether the legal provisions for obtaining therapeutic abortions were operating equitably across Canada (Badgley, 1977). Among of the findings were that:

> Of 559 general hospitals which met provincial requirements to do abortions, 271 or 48.5 percent had established therapeutic abortion committees, while 288 hospitals or 51.5 percent did not have committees.
>
> Two out of five Canadians did not live in communities served by hospitals eligible to establish therapeutic abortion committees.
>
> Hospitals with therapeutic abortion committees had on average four conditions the woman had to meet before the application for abortion would be reviewed: these included consent, length of gestation, social services review, residence, quotas.
>
> One out of three hospitals where abortions were performed had residency requirements or patient quotas regarding the number of abortions that were done.
>
> There were substantial differences in the provinces in the number of obstetrician/gynaecologists and other physicians who performed the abortion procedure owing to both personal preferences and hospital practice.

It was concluded that these factors result in sharp regional disparities in the accessibility of abortions so that this procedure, provided for in legislation, is in practice illusory for many Canadians.

The Committee also examined delays in obtaining abortions. After a woman first suspected pregnancy, an average of 2.8 weeks passed before a physician was seen. After this contact, there was on average an interval of eight weeks before the abortion was done owing to delays by physicians and hospitals.

The Committee proposed that the number and types of complications from therapeutic abortions might be reduced by:

the development and broader use of safer induction techniques;

providing abortions in specialized units with specially trained nurses and medical personnel.

In response to the Badgley report, Marc Lalonde, then federal Minister of Health, stated that he would discuss with the provinces "the feasibility of establishing women's clinics that are affiliated directly with a general hospital to provide family planning, fertility counselling, cancer screening, abortions, general maternal health, breast self-examination instruction, and related community services including counselling in parenting and family life." It was his position that "abortion counselling services should be provided in family planning facilities as long as all the possible options are fairly and clearly presented, and as long as the terms established by the Criminal Code are fully respected."

In 1980, the legislative body of the United Church of Canada issued a policy statement on abortion. The sections of the Criminal Code dealing with abortion were described as being unjust in principle, inequitable and unenforceable. The statement called on the federal government to "remove from the Criminal Code all sections presently relating to abortion to the extent that they relate to the termination of pregnancy within the first twenty weeks." Provincial governments were called on to provide facilities and personnel to meet the need for abortions and to refrain from laying charges against those who responsibly seek to meet this need.

In 1985, the Canadian Medical Association published a policy summary on abortion. The statement reiterated findings concerning unequal access to abortion services across the country. Therapeutic abortion committees were particularly singled out as increasing the stress levels of patients and extending the length of pregnancies thereby increasing the risk of complications. The policy statement went on to recommend the removal of all reference to therapeutic abortion committees in the Criminal Code. To further improve service provision, it was proposed that:

at least one hospital in all regions provide therapeutic abortion services, with the proviso that no hospital, physician, or health care worker be compelled to take part in abortion services;

> family planning advice and assistance be made available to all residents of Canada by health and educational agencies under the supervision of the medical profession

In April of 1986, the Status of Women Canada released a federal study recommending the repeal of abortion laws because services are not equally accessible in all parts of the country resulting in discrimination on the basis of economic status and place of residence. The law was viewed as creating unnecessary risks for the lives and health of women who do not have access to timely and safe legal abortion.

In the same year, the Committee on Medical Care and Practice of the Ontario Medical Association responded to the following Board directive:

> "...to examine critically the crisis in access to safe medical abortion in accordance with the law as it applies throughout the Province of Ontario...."

Among the findings were:

> a range in the availability of abortions in the Province, with abortion services being much less available in smaller centres than in large metropolitan areas;
>
> a high proportion of second-trimester abortions, particularly among those under 19 years of age;
>
> a decreasing number of hospitals performing abortions;

The report concluded that any woman who wants an abortion is probably able to obtain one "somewhere, sooner or later", but obtaining the service "often requires travel, and delays, with an excess of second-trimester abortions."

Delay in obtaining an abortion can have serious health consequences for the woman. A key variable is gestational age, defined as the length of the pregnancy calculated from the first day of the last menstrual period. A number of studies have found that the greater the gestational age when an abortion is performed the greater the risk of complications or death (Buehler et al., 1985):

U.S. data report that the risk of complications doubles from two to four per thousand abortions between eight and twelve weeks gestation, while at 17 weeks complications rise to 17 per thousand (Jaffe et al. 1981).

In Canada in 1974, the complication rates per 100 abortions were: 1.6 at 9-12 weeks and 16 at 17-20 weeks (Badgley et al. 1977).

From 1975-1979 there were complications in approximately three percent of the abortion cases. The complication rate was found to increase as a function of gestational age at the time of abortion with the risk being 11 times greater after 13 weeks gestation (Wadhera & Nair, 1984).

Similar findings were reported by Smith et al. (1978) in reviewing close to 19,000 abortion cases in Hawaii. Post abortion complications were found to be nearly five times as high at 13-16 weeks of gestation.

While death from a legal abortion is rare and mortality rates have been dropping, in 1978 the Centre for Disease Control in Atlanta reported .5 deaths per 100,000 abortions:

The death rate was reported to increase 40 to 60 percent per week for each week of delay after eight weeks (Jaffe et al., 1981).

Between 1972 and 1977 the death rate under nine weeks gestation was .6 per 100,000 but between 11-12 weeks and 13-15 weeks the rates rose to 2.7 and 7.5 respectively (Centre for Disease Control, 1977).

In Canada where far fewer abortions are performed in comparison to the United States and abortions reported occur in hospitals, there was only one death reported between 1974-1976 (MacKenzie, 1981), and there was one death in 1986.

A British study pointed out the importance of minimizing delay in the abortion process (Editorial, 1984). It was found that 20% of the women who had abortions between 20 and 23 weeks gestation had been referred before the end of the twelfth week. The law in Britain permits abortion up to 26 weeks.

THE USE OF ABORTION AS A MEANS OF BIRTH CONTROL

One question which is often raised in reviews of abortion services is whether abortion is used as a means of birth control. The Ontario Medical Association study referenced earlier, noted an increase in the number of repeat abortion cases. For example, in 1975 approximately 87 percent of the women having abortions had not had the procedure before, whereas in 1984, 78 percent were first time abortion cases.

Care must be taken before interpreting an increase in repeat abortions as indication that abortion is being used as an alternative to contraception. In the years since the law made provision for legal abortion, the number of women who have had first abortions has increased thereby creating a larger potential pool of repeat cases. Data from the U.S. demonstrated that the level of second abortions initially rose after the passage of abortion legislation, but then plateaus were reached.

A 1976 national patient survey in Canada found that of 4,754 women who had obtained abortions, 47 percent had conceived despite the use of a contraceptive, 25 percent had discontinued use of contraception, and 27 percent had never used contraception (Badgley et al. 1977). Berger et al. (1981) found in several studies, that women with repeat abortions had used contraception more extensively and had used more effective means than women seeking an abortion for the first time.

Between July and November 1986, of 1046 women referred by the Bay Centre for Birth Control for abortions, 53 percent had been using contraceptives at the time of conception. There were significant age differences, however with only 44 percent of the under 20 years olds using contraception compared to 53 percent of the 20-29 years olds, 63 percent of the 30-39 year olds, and 71 percent of the over 40 year olds.

Jaffe et al. (1981) have pointed out that:

> "...even if everyone were to practice contraception, and use the most effective medically prescribed methods, there would still be a very large number of unwanted pregnancies. None of the current reversible methods - not even the pill or intrauterine device - is failure-proof. These methods have failure rates that are high enough to result in a very large number of unwanted pregnancies each year, to which must be added the additional pregnancies that follow

inconsistent or ineffective use of the methods." (p. 5)

Tietze (1974) made statistical predictions that certain percentages of motivated contraceptive users would become pregnant resulting in the need for repeat abortions within ten years of the initial abortion. The calculations took into account contraceptive use, effectiveness, and age related fertility rates. His figures suggested that: repeat abortions could be expected within one year among up to 5 percent of oral contraceptive users and up to 24 percent of women using other methods of contraception; after ten years, 20-50 percent of the pill users and a majority of the users of other methods could be expected to experience at least one repeat abortion.

Vaughan et al. (1977) using U.S. data from the National Survey of Family Growth, reported that seven percent of married women wanting to delay having a family became pregnant using contraceptives, and four percent of women who wanted no more children conceived as a result of contraceptive failure.

Dryfoos (1982) examined the pregnancy experience of American women between the ages of 13-44 during 1978. Data sources included the Survey of Family Growth and John Hopkins Surveys of Young Women. It was estimated that there were 3.1 million unintended pregnancies among married women: 1.8 million among those using contraception, and 1.3 million among those using no contraceptive method.

In a 1978 article, Tietze examined the reasons the risk of a repeat abortion is higher among women who have experienced the procedure than among those who have not. The factors identified included:

age: the group that have experienced abortions are highly represented by women in their prime reproductive years;

sexual activity: with the exception of rape victims, all women who had abortions were sexually active and probably resumed sexual activity after the abortion.

fertility: all women with abortion experience were able to conceive, although following the abortion a percentage would undergo or their sexual partners would undergo surgical sterilization;

attitude to abortion: women who have had an abortion were not opposed to the procedure;

Thus the women having repeat abortions represent a group which are at greater risk of becoming pregnant.

There are also Canadian data to suggest that some women are at higher risk of requesting a repeat abortion. The national patient survey (carried out by The Committee on the Operation of the Abortion Law in Canada in 1977) indicated, for example, that repeat abortion cases were more likely among women who are single, have a higher level of education, work outside of the home, and have fewer previous live births.

ADOLESCENT PREGNANCY

Adolescent pregnancy has been declining steadily since the peak in the birth rate in 1959. Despite the fact that teenagers have become more sexually active, the concomitant societal acceptance and distribution of contraception has been responsible in part for this decline in the pregnancy rate. When the family planning programme of the Ministry of Health, Public Health Branch was instituted in 1975, the primary focus was on younger unmarried women who were not thought to have the same access to birth control as married and older women. Society at this time was changing its approach to teen pregnancy. As Orton & Rosenblatt (1986) have reported:

> "Twenty years ago, an unmarried adolescent woman, on finding herself pregnant, had to choose between marriage, illegal or self-induced abortion, or adoption. As new options became accessible via public programmes,...individual behaviour had shifted to utilize the new options and moved away from all three of the previous options....Now, as public programmes of prevention are becoming gradually accessible, adolescents are choosing to avoid pregnancy, as demonstrated by declining pregnancy rates." (p. 6)

In more recent years, there has been far more acceptance and financial support to the unwed mother. At the same time there has been more demand for services to terminate unwanted pregnancies so that young women can continue with their education and careers. Since 1974, there has been a steady increase in the

proportion of pregnant adolescents who have opted for abortion rather than to carry the pregnancy to term (Herold, 1984). In 1981 there were 61 abortions for every 100 live births among Canadian females under 20 years of age.

However because abortion services have not been readily and equitably accessible, those with the economic means to obtain an abortion were more likely to have abortions while less financially advantaged women kept their babies. (Badgley et al. 1977; Orton & Rosenblatt, 1986).

Another issue in the provision of abortion services to minors is the consent. Cerloof & Klerman (1986) found that when parental consent was required under the age of eighteen in the state of Massachusetts, the number of teenage abortions performed in the state was reduced by fifty percent. However, the number of abortions on this age group increased in surrounding states not having such specifications.

DELIVERY OF ABORTION SERVICES

When many countries legalized abortion, hospitals were viewed as the appropriate providers of safe abortion services. Since then, studies have demonstrated that abortions can be performed safely in other types of facilities, (Tietze & Henshaw, 1986). The complication rate for all abortions performed in nonhospital facilities, is no higher than for those which take place in hospitals (Grimes et al., 1981).

In a number of European countries, including the Netherlands, Poland, and West Germany, approximately half of the abortions are performed in non-hospital facilities. In France in 1982, 53 percent of abortions were performed in 90 "centres d'interuption voluntaire de grossesse" which were administered by hospitals but were in practice separate abortion clinics. The French government ordered all public hospitals that could not meet the demand for abortions to provide such clinics.

The most extensive experience in non-hospital abortion services has been in the United States since 1973, when a Supreme Court decision legalized abortion throughout the country. Since there were no provisions in the U.S. stipulating that abortions had to be performed in hospitals, freestanding clinics became the accepted mode of delivery with the majority of women paying for the procedure

themselves. Separate specialty clinics were establishedwith backup arrangements in case of emergencies.

In 1978 at least 75 percent of the clinics were private enterprise and depended on large case loads to continue in operation (Jaffe, 1984). The competition has been a factor in keeping down the charges to women. Less than half of these clinics were licensed by state or local health agencies. By 1982, 82 percent of all abortions in the U.S. were performed in freestanding clinics (Tietze & Henshaw, 1986).

ABORTION STATISTICS IN ONTARIO

TRENDS

Table 1 presents abortion statistics for Ontario in the years 1975-1985. The number of abortions performed each year steadily increased until 1983 when a downward trend began. Among women who have had abortions since 1975, there has been a decrease in the percentage of teenagers seeking abortions and the number of abortions performed between 13-20 weeks.

A larger percentage of abortions are being performed before 12 weeks of gestation. Between 1975 and 1985, there was a 7.5 percent increase in abortions before 12 weeks and those performed beyond 12 weeks declined by 6.7 percent. The greatest change occurred in abortions performed before eight weeks gestation going from 20.4 to 27.7 percent (Table 1).

In Ontario 11 percent of abortions are performed beyond 12 weeks, which is a higher percentage than in most other countries where abortion is legal.

There has been an increase in the percentage of unmarried women obtaining abortions, women who have had previous abortions, and a slight increase in the number of woman having abortions who have had a child.

There have been no substantial changes in the proportion of abortions to total pregnancies.

Table 2 presents the percentage of therapeutic abortions by procedure for the years 1976-1984. While there has been no substantial change in the percentage of D & C's, there has been a small decrease in the percent of saline/urea procedures and hysterotomies/hysterectomies. The proportion of "other" procedures has increased.

From 1976 to 1984 there has been an increasing trend to provide abortion on a hospital out-patient basis, rather than admitting patients to in-patient care. (Table 3) Despite this trend, in 1984, 28 percent of abortions were performed as in-patient procedures.

Ontario data confirmed previously reported findings of the relation between abortion complications and gestational age. Table 4 presents data from 1976, 1981, and 1984. There were twice as many reported complications for women with gestational age 13 weeks and above compared to gestational age under 13 weeks. The rate (per 100 gestational age specific abortions) was ten times higher for the group of women with gestational age 13 weeks and above. The majority of complications for over 13 weeks is for "retained product." The overall rate of complications dropped between 1976 and 1984.

Reported complications are those which occur at the time of the procedure and do not include complications treated in physicians' offices, clinics and emergency departments. The figures also exclude women who have to be readmitted to hospital for later serious complications.

AVAILABILITY IN COUNTY OF RESIDENCE

In 1985 in over half of Ontario counties, representing 30 percent of Ontario's population, the majority of women obtaining abortions had the procedure outside their place of residence (Table 5b and Figure 1). In a third of these counties, over 75 percent of abortions were performed elsewhere in Ontario, and in an additional 8 counties, 50-74 percent of the abortions were performed elsewhere in the province. These trends were more prevalent in counties having populations of less than 100,000. In total, 5303 women obtained their abortions in hospitals somewhere in the province outside their county of residence, representing 19 percent of the number of abortion performed.

More than 50 percent of all hospital abortions in Ontario are performed in metropolitan Toronto. In 1985 there were 14,778 abortions performed in Toronto, of which 83 percent were for city residents.

Second trimester abortions, usually defined at a gestational age of over 12 weeks, were not performed in 82 percent of the counties (Figure 2) representing approximately 50 percent of the Province's population. Women requiring late abortions had to go to one of the eight counties performing such procedures or find a freestanding clinic that would do them. Five of these counties have university medical centres. The on-site visits provided information that many women requiring second trimester abortions had to be referred to the United States because of the limited number of referrals which were accepted even in these large centres.

In five counties there were no therapeutic abortion committees in any of the hospitals. Out of 176 accredited acute care hospitals, 95 (54%) had therapeutic abortion committees. But 12 of these hospitals did no abortions in 1986. In an additional nine hospitals, there were fewer than ten abortions on average performed per year and in another seven fewer than 30 abortions were done each year. The absence or small numbers of abortions was not due to lack of demand. Women from these areas were having their abortions elsewhere.

Taking a look at the county distribution, in areas where over 50 percent of the women went elsewhere for their abortions, 44 percent had one therapeutic abortion committee (TAC), 28 percent had two, and 8 percent had three TACs (Table 6). Obviously the existence of a therapeutic abortion committee is not the key to a woman obtaining an abortion in the county of her residence.

One surprising finding was that in counties where there is restricted access to abortion, teenagers are viewed as having greater need and appeared to be given priority. Older women, married and single, are less likely to be candidates for limited local services.

The above figures do not include women who went to the United States or to freestanding abortion clinics in Ontario and Quebec. The number of U.S. abortion clinics listed in Ontario telephone directory yellow pages is suggestive of the demand for such services. In 1984, 2200 Canadian women were reported to have obtained abortions at freestanding clinics in upper New York state, Michigan, and Minnesota; Ontario women are known to use these clinic services. In 1986,

approximately 3700 abortions were performed in clinics in Toronto, of which two-thirds were for Toronto residents. An additional 23 percent of the patients came from within 120 kilometres of Toronto.

COMPONENTS OF ABORTION SERVICES

PREGNANCY TESTING

The first step in the abortion referral process is the determination of pregnancy. The options available to the woman include family physician, public health clinics, specialty birth control clinics, or self testing through use of over-the-counter products.

Whatever option the woman chooses, the essential factor is that determination of pregnancy be made as soon as possible. Standard urine tests available through most clinics and pharmacies cannot be done until 42 days after the first day of the last menstrual period or a gestational age of six weeks. Tests which determine pregnancy at an earlier age are becoming more available and thus pregnancy is more likely to be diagnosed sooner.

COUNSELLING AND REFERRAL

Once the determination of pregnancy is made comes the assessment of the impact of the pregnancy of the woman's health and life. Depending on whom she has consulted for the determination of pregnancy, she may or may not have assistance in considering all the options available to her. If her physician is philosophically opposed to abortion, she may not be able to discuss this option and may be faced with searching out counselling and abortion referral services on her own. Although the Canadian Medical Association policy on abortion states that physicians opposed to the procedure should provide referral elsewhere, family planning clinics report that women have had difficulty in obtaining such referrals.

Most of the 54 public health family planning clinics offer women pregnancy testing, pregnancy counselling, referral to abortion services, and post abortion counselling. Direct referral to gynaecologists is restricted in some areas because of: local policies of the Board of Health, the interpretation of Ministry Guidelines for Family Planning Services, referral patterns of the medical community, and availability of services in the community.

One out of four woman having abortions in Ontario have contact with these units when they are faced with the possibility of an unwanted pregnancy. Very often the women seeking out family planning agencies are teenagers or women who do not have a family physician with whom to discuss the abortion option.

In cities where the majority of hospital abortions are performed, there are two types of referral pathways. One is a hospital abortion clinic which provides counselling, assessment of the pregnancy, presentation of the case to the therapeutic abortion committee, and scheduling of the procedure. If the woman chooses this route, she must make her own appointment for the initial visit. In one city, patients seeking an abortion through the clinic have to phone on a specific day at a specific time to be seen the following week. Repeated calls are usually required before the call is answered. If all the appointment slots are taken for the one day a week the clinic is held, patients must wait until the following week to again phone and try to schedule an appointment.

The other referral route, more common in smaller centres and non-teaching hospitals, is directly to the gynaecologist from the family physician or the physician in a family planning clinic. In this case, the physician must write a letter of referral to the gynaecologist who in turn presents the referral to the therapeutic abortion committee. Thus the woman needs to have a family physician who is willing to make a referral to a gynaecologist, and to find a gynaecologist willing to present the case to a therapeutic abortion committee (TAC). The physicians receive no financial remuneration for either writing the letters or presenting cases to a TAC.

Abortion is not a procedure which all gynaecologists are willing to perform. Those doctors willing to perform the service must in a sense compensate for the reluctance of their colleagues or the unwillingness of other hospitals to allow abortions to be performed.

THERAPEUTIC ABORTION COMMITTEES

The TACs receive letters of referral for abortions and hold meetings to review the letters and hear the presentations of the gynaecologists concerning patients. General practitioners make up the largest group of doctors who are members of the committees. A few hospitals require membership by gynaecologists,

psychiatrists, or women physicians. Difficulty has been experienced by some hospitals in recruiting these categories of members because of a shortage of psychiatrists in their area, the conflict of having a gynaecologist on the committee who may be performing abortions, and the unwillingness of others to serve.

The number of members on the TAC ranges from three to five although up to seven members sit on some committees. When five or seven members have been appointed and no quorum is stated, a majority of the committee (three to five) must be present and three must approve each abortion. This has caused problems in several of the hospitals contacted, where it was not possible for an adequate number of members to be present and the meeting had to be rescheduled. Thus precious time was lost and the abortion delayed to a more advanced gestational age.

The TAC will assess the medical necessity of the abortion procedure. There are, however, other criteria the woman must meet for the abortion to be approved. Criteria are established by each hospital and include:

1. length of gestation

   The norm in Ontario is for hospitals to limit abortions to 10-12 weeks. A few hospitals perform D & E's up to 14-16 weeks. Only twelve hospitals perform mid-trimester abortions using intra-amniotic techniques. A few hospitals will perform mid-trimester abortions under special conditions (eg. young teenagers or for genetic reasons). Five hospitals do most of the abortions beyond 14 weeks.

2. parental consent for pregnant teenagers up to age 18

   Although the Public Hospitals Act (Regulation 865) states that 16 is the age of consent for surgical operations in hospital, 10 percent of the hospitals contacted required parental consent up to the age of 18.

3. letters of referral

   All hospitals require a letter or presentation by the gynaecologist indicating the reason for the abortion stated in terminology that meets the requirement of the law. A majority of hospitals require a second

letter from the family physician supporting the request. Three hospitals require a third letter from a second family physician. Doctors who write such letters must be members of the active staff of the hospital. This limits referral to those women who have access to an accommodating local physician.

4. assessment by a social worker or psychiatrist

In ten of the hospitals visited, a report from a social worker or psychiatrist is required as part of the documentation to the therapeutic abortion committee. The content of this documentation does not always seem to have a bearing on the decision of the TAC.

Members of TACs interviewed indicated that the reasons for refusing approval for abortion, even with the above criteria being met were: inadequate documentation by the referring physician (although new documentation could be resubmitted); repeat abortions, and the woman being married.

Close to 95 percent of the 150 physicians interviewed stated that the TAC served no useful purpose and there was almost unanimous support for the abolishment of the committee. The overall operation of the TAC is an anomaly in the provision of both health and legal services. Walker (1986) summerized the situation when he wrote:

"This Committee violates one of the most cherished principles in the practice of medicine, namely that physicians should never make medical decisions without seeing the patient. And, unlike in a court of law, the patient in question has no grounds for appeal from its decision. The TAC is an insult to both those who favour and oppose abortion and is one of the greatest examples of malpractice this nation has ever seen. It is a modern medical ritual that has much in common with the Zulu rain dance. Zulu natives realized their rain dance didn't bring them much rain but it made the tribe feel better."

OPERATING ROOM BOOKINGS

Once the TAC has approved the abortion, the next step is for the procedure to be scheduled in the OR or short stay unit. Often the decision as to whether a woman will have her procedure as an in-patient or out-patient, is based on the availability of space rather than her individual needs.

As pressures on hospital budgets becomes tighter, abortions have to compete with other procedures. One of the major reasons why some hospitals have cut back on the number of abortions performed is the competition for OR time and inability to extend hours because staff do not want to work late in the day or on Saturdays. One of the first services to be cut back when a hospital experiences too many competing demands for OR time is abortion.

In most hospitals, performing a significant number of abortions, there are no designated block bookings for the procedure. With an ever decreasing number of gynaecologists willing to perform the procedure, the remaining physicians are not given extra OR time as a consideration for their willingness to perform the procedure.

The burden of abortion falls on the physicians, usually gynaecologists, willing to perform the procedure, who become in essence the gatekeepers. In 18 of the counties where abortion services are provided, one or two physicians are performing all the procedures. In the event of illness, vacation or departure of these doctors, access to abortion becomes more restricted or unavailable.

PROCEDURES

The procedures used in Ontario in 1984 for abortions up to 12 weeks included: suction dilatation and curettage (87%), and to a lesser extent surgical D & C (4%). Although there is general consensus in the literature that the safest procedure between 12 and 16 weeks is suction dilatation and evacuation, very few gynaecologists offer this procedure beyond the first trimester. (Castadot, 1986; Stubblefield, 1986). The usual practice in Ontario hospitals for second trimester abortions is intra-amniotic installation of hypertonic saline, prostaglandins, or urea.

With few exceptions, abortions are performed under general anaesthesia in Ontario. By way of contrast, many abortions performed elsewhere use local anaesthesia, with or without intravenous medication. Many of the hospitals visited mentioned the difficulty of finding anaesthetists willing to take part in the procedure. In addition to the usual risks of general anaesthetic, its use with abortions increases the risk of cervical laceration, perforation and haemorrhage (Stubblefield, 1986).

Prior to the abortion, there are procedures which can be used to to dilate the cervix. Among these procedures are laminaria tents, hydrophilic dilators, and prostaglandin preparations. While laminaria tents have been used for centuries to achieve dilatation of the cervix, their association with illegal abortions has minimized their use in recent years (Darney, 1986). Dilators are useful in both first and second trimester situations to facilitate the abortion procedure and help reduce the risk of cervical laceration and perforation of the uterus (Smith et al., 1978).

In Ontario there is limited use of dilators. One explanation for this may be that the procedure is not listed as an insured service. When a tent is inserted in the physician's office, the patient must pay for both the procedure and the dilator. Another factor in a physician's decision not to use tents, may relate to the necessity of bringing the patient into the office at least four hours prior to the abortion procedure. In practice the patient usually has the tent inserted the day before the abortion, thus necessitating another visit.

COMPLICATIONS

One of the major reasons for legalizing abortion under the Criminal Code was to reduce the risk to the mother's life by moving abortions into hospitals where there was strict medical supervision. Since legalization of abortion, improved techniques have further reduced the risk of medical complications. Abortions under twelve weeks carry a substantially lower rate of complications. For a variety of reasons not all abortions can be performed within this time frame because of difficulties associated with decision making, diagnosis and referral.
The lower complication rate for earlier abortions has been a major reason for the 10 - 12 week cut-off by most community hospitals. While this has substantially reduced the number of complications experienced by community hospitals and

physicians, it has been an important cause of delay for women over 12 weeks pregnant, contributing to the high incidence of mid-trimester abortions reported in Ontario.

REFERRAL PROBLEMS AFTER MAY 1986

Physician reactions to the legislation banning extra-billing created a number of problems for women seeking abortions:

TACs in a number of hospitals refused to meet so that no abortions could be performed in the affected hospitals.

Even where TACs continued to meet, the gynaecologists and anaesthetists in many hospitals refused to provide abortion services.

Now that Bill 94 has been passed, some gynaecologists have continued to restrict services.

Since May, there has been a significant decline in the number of hospitals providing second trimester abortions.

Between May and August of 1986, there was a significant decline in the number of abortions being performed. In September the numbers increased.

ATTITUDES TOWARDS ABORTION

Induced abortion carries with it considerable controversy and stigma which affects both the patient, the institution providing the service, as well as the health care providers. Abortion, unlike any other health service, must be performed under the conditions of the Criminal Code and is shadowed by the divergence of societal opinion on the morality of the the procedure. As a result the woman must not only deal with her own feelings about the appropriateness of her decision to terminate a pregnancy, but face attitudes about the provision of abortion including:

1. family reaction to the pregnancy;

   The pregnant teenager or unmarried woman may find herself without the kind of family support that could be expected in the face of other medical interventions. The woman must deal with reactions to her sexual activity as well as the issue of the pregnancy. In the case of minors, the decision to proceed or not may be made by parents or guardians. There are cases where a woman has been forced to carry the pregnancy to term against her wishes or had to resort to drastic measures to obtain the procedure out of the province.

2. attitudes toward married women who seek abortion;

   Married women who seek abortions are sometimes viewed as seeking an easy way out of responsibility. In some locations married women are not referred to the community hospital because it is known that members of the TAC will be reluctant to give approval in this situation.

3. attitudes of the community to the hospital and health professionals that provide abortion services;

   There has been regular harassment of hospitals and medical personnel who perform abortions by those who disagree with the entire concept of legal abortion. Hospitals have been threatened with the loss of financial support from sectors of the community and consequently some hospitals disbanded their therapeutic abortion committees or reduced the number of abortions performed in their facility.

   Some gynaecologists have reported a decrease in general referrals, once they were known as willing to accept abortion referrals. Even the families of physicians performing abortions have in some instances been subject to abuse in home or school settings.

4. attitudes by health professionals to the procedure;

   Health professionals share the divergence of opinion over abortion. Women who have undergone an induced abortion have been subjected to nonsupportive behaviour by medical and other hospital staff and have

received comments that reflect outright hostility. Nurses and counsellors often warn prospective abortion candidates of the negative reactions they may experience.

5. stereotypes about the type of women who seek abortions and about their irresponsible use of contraception;

Women who request abortions are often viewed as promiscuous and sexually irresponsible. As noted earlier in the review of the literature, contraceptive failure is a major cause of unintended pregnancy, and there are numerous factors which contribute to repeat abortions.

6. attitudes about women who require repeat abortions;

These women, often viewed as irresponsible users of contraception, may be faced with a negative response from therapeutic abortion committees and may be subjected to punitive measures. For example there are a number of hospitals which require the woman to agree to sterilization before approval is given for a repeat abortion. Another example is the use of minimal local anaesthetic for repeat cases although the usual practice is a general anaesthetic.

While contraceptive counselling should be a major component of all abortion referral services, negative attitudes and stereotyping can increase the stress on the woman rather than help her deal with the problems of the unintended pregnancy.

7. threats to the confidentiality of the procedure;

There have been leaks and thefts of confidential operating room schedules in order to find out the identity of women scheduled for abortions. Hospitals routinely use extra means of protecting the identity of women referred for abortions so the patients will not be harassed. For example, the patients may be listed on operating room schedules by initials only or coded in some way.

SUMMARY OF FINDINGS

The present referral process for abortions does not facilitate timely and efficient abortion services, nor does the system provide optimal support to the women in need of this type of health care intervention.

There are considerable geographic inequities across the Province in the availability of abortion services. In over 50 percent of Ontario counties, the majority of women having abortions obtained the procedure elsewhere. This means that one in five women who obtain abortions in hospitals, go outside their county of residence for the procedure. In addition, a minimum of 5000 Ontario women obtain abortions each year in freestanding clinics in Canada and the United States. Women are being referred to the two freestanding clinics in Toronto from all over the Province.

Out of 176 accredited hospitals, 46 percent do not have therapeutic abortion committees. Of the 95 hospitals which have committees, 12 did no abortions in 1986. In an additional nine hospitals, there were fewer than ten abortions on average performed per year and in another seven, fewer than 30 abortions were done each year.

The norm in hospitals is to limit abortions to 10-12 weeks gestation. This creates difficulties for the significant number of women faced with later abortions.

When women obtain abortions in hospitals away from their residences, repeated travel is required as the women must return for each step in the referral process. Women must rely on their own financial resources for transportation and accommodation thus adding hardship or even a barrier to women without adequate economic resources.

The standard methods of providing abortion services in the province are costly in terms of manpower resources and hospital facilities while at the same time providing inadequate amount of counselling and support services to women before and after the procedure. Abortion procedures in general have not kept pace with the trend to provide services, of a similar level of technical difficulty, entirely on on an out-patient basis. Whereas all abortions in Canada must be performed in hospitals, by comparison in the United States, 82 percent of the abortions were

performed in non-hospital facilities. The complication rates are no higher than for abortions performed in hospital.

Abortions are generally performed by gynaecologists using general anaesthesia; this requires the availability of anaesthetists and operating rooms. Hospitals are often hard pressed to find time in the busy operating room schedules to fit in abortion procedures. In most hospitals, abortions are not viewed as a priority for scheduling. Gynaecologists must fit abortions into their allotted time in operating rooms. Although abortions can be performed in minor procedure rooms with no jeopardy to the patient, this is an unusual practice.

The responsibility for abortions falls on the shoulders of the gynaecologists and anaesthetists willing to do the procedure. The number of these physicians has been decreasing and in 18 counties where the services are provided, one or two physicians perform all abortions. When these doctors are unavailable, women must seek abortion services elsewhere. Despite this, there is a reluctance to have general practitioners perform abortions in hospitals.

Hospitals are under pressure from anti-abortion groups in the community and though a hospital may wish to provide abortion services there may be threats of: the loss of financial donations, harassment of staff performing abortions, leaks of confidential operating room lists, and picketing on a regular or annual basis.

There is a practice, in certain geographic areas, for patients to be charged administrative fees for components of the referral process which are uninsured. The fees vary from $20 - $500. These costs, added to travel and accommodation expenses, place a burden on many women and may make it impossible for some to obtain an abortion in a hospital setting.

The physicians and other health care professionals interviewed felt strongly that abortion should be removed from the Criminal Code and that abortion be a decision between the woman and her doctor. Furthermore members of the therapeutic abortion committees interviewed, stated that the committees do not serve a useful function other than meeting the requirements of the law.

Stigma associated with the abortion procedure and negative attitudes towards the procedure by health providers, create a hostile and nonsupportive climate in some hospitals for the provision of this health service.

There have been advances in abortion techniques during the past fifteen years which have reduced morbidity and mortality rates associated with legally induced abortions. Hospital statistics do not reflect the wide use of these more advanced procedures.

There is under-use of cervical dilatation techniques which would reduce post abortion complications. There are many reasons for this which include the need for an extra visit as well as the additional charges to the patient for a procedure which is not covered in the OHIP Schedule of Benefits.

There is a high incidence of second trimester abortions in Ontario, particularly among teenagers, and this is attributable in part to delays in the abortion referral process. The more advanced the gestational age at the time of abortion, the greater the probability of complications occurring.

The reduced rate of unwanted pregnancies among unmarried teenagers reflects the availability of government funded family planning programmes in all health units in Ontario.

The assumption that women are using abortion as a means of birth control has been disproved by numerous studies in Canada and the United States. Contraceptive failure is the foremost reason for unintended pregnancy.

While the number of woman seeking a repeat abortion is increasing, this reflects the greater pool of women who have had abortions. These women are for the most part still sexually active, in their most fertile years, subject to contraceptive failure, and thus still at risk of an unintended pregnancy.

Despite the above problems, in 1985 over 27,000 Ontario women obtained abortions in hospitals in the province.

OPTIONS FOR ABORTION SERVICE DELIVERY IN ONTARIO

A number of projects are proposed to facilitate access to services for women faced with an unwanted pregnancy. Each of these projects would be under the jurisdiction of a hospital board or several hospital boards with approval for abortion services provided through hospital therapeutic abortion committee mechanisms. The proposed projects which follow offer a variety of approaches which would meet the varied needs of differing communities throughout the province and could be established on a regional basis where appropriate.

1. MULTI-PURPOSE WOMEN'S CLINICS:

The exisiting women's clinics in several Ontario hospitals, some already providing abortion services, could be expanded to include surgical procedures on the premises. This approach to comprehensive women's health care has been advocated by many groups with special concerns about the health needs of women. This could be approached on a regional basis in major centres with a large referral population.

services provided: the focus would be on a full range of health services specifically related to women from puberty to the older years including cancer screening, birth control, prenatal care, and services related to unwanted pregnancy (diagnosis and assessment, counselling concerning options, surgical procedures for first trimester abortion, referral to hospital for second trimester abortion, and post abortion counselling),

staffing: multidisciplinary staff including nurse practitioners, public health nurses, social workers and other health professionals as required for the programs, with family practitioners, paid sessional fees, providing the medical services

2. REGIONAL CENTRES AFFILIATED WITH BUT NOT NECESSARILY LOCATED IN A HOSPITAL

This option could provide abortion services on a regional basis throughout the province. The centres would be designated as single purpose providing all

services related to abortion. The centres could be located in existing out-patient units or birth control units affiliated with hospitals. Such centres should be located in larger cities with a high volume of referrals.

services provided: all service related to abortion: assessment, counselling, all aspects of the abortion procedure, post abortion counselling,

staffing: would be staffed by multidisciplinary support staff and physicians on sessional pay.

3. INTER-HOSPITAL COUNSELLING AND REFERRAL CENTRES

Under this option, one or more hospitals would share counselling services and bookings for procedure rooms. An on-site TAC could serve all hospitals. This model could be adapted to any community and any volume of referrals, and could even be applied on an inter-city basis. Exisiting ambulatory care settings such as family planning clinics or community health centres could provide facilities for this service.

services provided: assessment, counselling, booking of a physician who would do the procedure in a cooperating hospital, on-site TAC approval, and post abortion follow-up.

4. SATELLITE MEDICAL SERVICES WHICH TRAVEL TO SMALLER COMMUNITIES

This programme is appropriate for communities with an accredited hospital agreeable to having abortions performed. A gynaecologist from a cooperating centre would provide services on an on-going or ad hoc basis. TAC approval could be obtained through teleconferencing.

services provided: the service would bring physicians to communities to perform the surgical procedure; local counselling and nursing personnel would be utilized for all other components of the referral process.

setting: local hospitals would provide teleconferencing facilities for the TAC approval, and would schedule operating room space for the visiting physician to do the procedure.

remuneration: sessional fees would be paid to the physicians who served on the teleconference for TAC approval; physicians performing the procedure would be paid by an alternative arrangement which would take into consideration the distance travelled and the time involved.

REFERENCES

Abortion: Medical Progress and Social Implications. Ciba Foundation Symposium 115. London: Pitman, 1985.

Access to Family Planning Clinics in the City of Toronto: A Study of Clinic Users in 1985. City of Toronto Department of Public Health, December, 1986.

Badgley, R.F., Caron, D.F., & Powell, M.G. Committee on the Operation of the Abortion Law. Ottawa: Supply and Services Canada, 1977.

Berger, C., Gold, D., Gillett, P., Andres, D., & Kinch, R. Repeaters: Different or Unlucky? In Sachdev, P. Abortion Readings & Research, Toronto, Butterworth & Co. Inc., 1981.

Buehler, J.W., Schulz, K.F., Grimes, D.A., & Hogue, C.J.R. The risks of serious complications from induced abortion: Do personal characteristics make a difference? Am. J. Obstet. Gynecol., 1985, 153(1), 14-20.

Canadian Medical Association Policy Summary: Abortion. Canadian Medical Association Journal, 1985, 133, 318A.

Castadot, R.G. Pregnancy termination: techniques, risks, and complications and their management. Fertility and Sterility, 1986, 45(1), 5-16.

Cates, W., Schultz, K.F., Grimes, D.A., Tyler, C.W. The effect of delay and method of choice on the risk of abortion morbidity. Family Planning Perspectives, 1977, 9(6), 266-273.

Center for Disease Control. Abortion Surveillance. Atlanta, September 1979.

Cerloof, V.G. & Klerman, L.V. American J. Public Health, 1986, 76, 397-400.

Darney, P.D. Preparation of the cervix: Hydrophilic and prostaglandin dilators. Clinics in Obstetrics and Gynaecology, 1986, 13(1), 43-51.

Dryfoos, J.G. Contraceptive use, pregnancy intentions, and pregnancy outcomes among U.S. women. Family Planning Perspectives, 1982, 14 (2), 81-94.

Editorial. Late abortions: There is madness in our methods. The Practitioner, March 1984, 228, 247-249.

Grimes, D.A., Cates, W., & Selik, R.M. Abortion facilities and the risk of death. Family Planning Perspectives, 1981, 13,(1), 30-32.

Herold, E.S. Sexual Behaviour of Canadian Young People. Markham: Fitzhenry & Whiteside Ltd., 1984.

Jaffe, F.S., Lindheim, B.L., & Lee, P.R. Abortion Politics. New York: McGraw-Hill Book Company, 1981.

Mackenzie, P. The Canadian abortion experience since the 1969 abortion law. In P. Sachdev, Abortion Readings and Research, Toronto: Butterworth & Co. Inc. 1981.

Options for Abortion Policy Reform: A Consultation Document. Ottawa: Law Reform Commission of Canada, September 1986.

Orton, M.J. & Rosenblatt, E. Adolescent Pregnancy in Ontario: Progress in Prevention. Report Number 2. Hamilton: Planned Parenthood of Ontario, 1986.

Report to the O.M.A. Board of Directors from the O.M.A. Committee on Medical Care and Practice, March 1986. Access to safe medical abortion in accordance with the law as it applies throughout the province of Ontario.

Smith, R.G., Palmore, J.A., & Steinhoff, P.G. The potential reduction of medical complications from induced abortion. Int. J. Gynaecol. Obstet., 1978, 15, 337-346.

Statistics Canada. Therapeutic Abortions 1983-1984. Ottawa: Supply and Services Canada, 1986.

Stubblefield, P.G. Surgical techniques of uterine evacuation in first- and second-trimester abortion. Clinics in Obstetrics and Gynaecology, 1986, 13(1), 53-70.

Teen Users of Family Planning Clinics. Toronto: Ministry of Health, Public Health Branch, 1984.

Tietze, C. The problem of repeat abortions. Family Planning Perspectives, 1974, 6(3), 148-150.

Tietze, C. Repeat abortions - Why more? Family Planning Perspectives, 1978, 10(5), 286-288.

Tietze, C.. & Henshaw, S.K. Induced Abortion, A World Review 1986, New York: The Alan Guttmacher Institute, 1986.

Vaughan, B., Trussell, J., Menken, J., Jones, E.F. Contraceptive failure among married women in the United States, 1970-1973. Family Planning Perspectives, 1977, 9(6), 251-258.

Wadhera, S. & Nair C. Early complications of legal abortions, Canada, 1975-1979. World Health Statistics Quarterly, 1984, 37, 84-91.

Walker, K. Who's guilty, Morgantaler or us? Pro-Choice News, 1986, Summer, 8-9.

APPENDICES

APPENDIX 1

TERMS OF REFERENCE FOR A STUDY TO REVIEW ACCESS TO THERAPEUTIC ABORTION SERVICES IN ONTARIO

1. Review with those Ontario hospitals that provide therapeutic abortion services to

    a) identify the demand and availability of services by geographic area

    b) identify program components that women require and the means of achieving optimum provision of these components

    c) review the referral patterns and scheduling process

    d) review the operation of the Therapeutic Abortion Committee

    e) encourage the development of this service as a total program.

2. To work with the public health units in Ontario to identify needs in their family planning programs and to examine ways in which the programs can be co-ordinated with those provided by hospitals.

3. To work with local hospitals, public health units etc., to develop a regional or local referral system for birth control services.

4. To work with concerned community groups, ie. Planned Parenthood etc., to develop informational and educational programs on family planning.

5. To identify the resources required to assist and to expand these services in hospitals, health units, etc.

June 17, 1986

TABLES

TABLE 1: CHARACTERISTICS OF WOMEN OBTAINING ABORTIONS
ONTARIO: 1975-1985

		1975	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985
Reported Number of Therapeutic Abortions		24,856	26,724	27,715	29,196	30,602	30,819	30,391	31,235	28,351	28,199	27,274
Characteristics		Percentage Distribution										
Age:												
19		30.5	30.2	30.2	30.0	30.2	30.1	28.4	27.7	26.2	24.4	23.3
20-29		48.3	48.9	48.9	49.3	49.6	49.8	51.1	51.6	52.3	53.7	54.2
30	100%	21.2	20.9	20.9	20.7	20.2	20.1	20.5	20.7	21.5	21.9	22.5
Marital Status:												
Married		34.3	34.2	32.6	30.7	27.6	26.3	25.5	24.6	24.2	24.0	23.8
Unmarried	100%	65.7	65.8	67.4	69.3	72.4	73.7	74.5	75.4	75.8	76.0	76.2
Gestation (in weeks)												
8		20.4	22.3	24.0	24.5	23.7	21.6	21.9	20.6	23.4	24.8	27.7
9-12		61.9	62.2	62.0	62.1	63.6	65.2	65.0	65.9	64.3	63.3	61.2
13-20		17.6	15.4	13.9	13.4	12.6	13.1	13.0	13.4	12.2	11.8	10.9
21	100%	0.1	0.1	0.1	0.1	0.07	0.08	0.1	0.1	0.1	0.1	0.1
No. of Previous Abortions												
0		87.3	85.6	84.9	82.2	82.3	81.7	80.4	74.7	78.8	77.9	60.6
1		6.9	8.2	8.7	10.4	11.4	11.8	12.6	12.6	13.6	13.4	11.1
2+		1.0	0.9	1.1	1.9	1.9	2.1	2.3	2.5	2.6	3.1	3.8
Unknown	100%	4.8	5.3	5.3	5.5	4.4	4.4	4.9	5.2	4.9	5.5	25.5
Number of Live Births												
0		53.2	53.7	55.2	55.8	58.6	60.5	59.4	59.7	59.5	58.1	57.6
1		14.9	15.6	16.3	15.8	15.4	15.3	15.6	15.8	16.0	16.5	16.7
2		15.8	15.7	15.0	15.0	14.2	13.5	14.1	13.8	13.8	14.2	14.1
3+	100%	16.1	15.0	13.5	13.4	11.8	11.7	10.9	10.7	11.7	11.2	11.6
Proportion of Abortions to total Pregnancies												
Abortion		16.3	17.7	18.2	19.3	19.9	19.8	19.8	19.9	18.2	17.6	17.0
Livebirth		82.8	81.4	81.0	80.0	74.4	79.5	79.6	79.4	81.2	81.9	82.5
Stillbirth	100%	0.8	0.8	0.7	0.6	0.6	0.6	0.6	0.6	0.5	0.4	0.4

TABLE 2

THERAPEUTIC ABORTIONS (PERCENT) BY PROCEDURE

ONTARIO: 1976-1984

Year	D & C (surgical and suction)	Saline Urea	Hysterotomy and Hysterectomy	Other
1976	91.4	5.6	1.3	1.7
1978	90.2	4.1	0.7	5.1
1980	90.2	3.8	0.3	5.6
1982	90.9	4.1	0.2	4.8
1984	90.5	3.3	0.1	6.1

February 1986

TABLE 3

THERAPEUTIC ABORTIONS (PERCENT)

BY IN AND OUT PATIENT CARE

ONTARIO: 1976-1984

YEAR	OUT PATIENT	IN PATIENT
1976	34.5	65.5
1978	49.4	50.6
1980	58.3	41.7
1982	68.0	32.0
1984	72.0	28.0

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TABLE 4

THERAPEUTIC ABORTIONS
COMPLICATIONS BY GESTATIONAL AGE
ONTARIO: 1976, 1981 AND 1984

COMPLICATIONS	1976		1981		1984	
	≤12w.	≥13w.	≤12w.	≥13w.	≤12w.	≥13w.
. Rate: % abortions by gest. age	1.0	10.3	0.8	10.2	0.6	5.4
. Hemorrhage	37	21	32	19	43	20
. Infection	35	37	32	23	11	16
. Laceration of cervix	60	23	75	19	49	8
. Perforation of uterus	43	5	30	7	16	4
. Retained product	45	334	29	334	25	232
. Other	12	1	33	14	20	13
Sub Total	232	421	231	416	164	284
TOTAL	653		647		448	
Rate: % of all abortions	2.4		2.1		1.5	

March 1986

TABLE 5a: NUMBER OF COUNTIES WHERE WOMEN OBTAIN ABORTIONS OUTSIDE THEIR PLACE OF RESIDENCE*

Population Size	Number (Percent) of Counties**							
	100,000		100,000-500,000		500,000		TOTAL	
Number of women obtaining abortions in Ontario, outside county of residence								
99	22	(45)	13	(27)	1	(2)	36	(73)
100-199			4	(8)	1	(2)	5	(10)
200	4	(8)	3	(6)	1	(2)	8	(17)
	26	(53)	20	(41)	3	(6)	49	(100%)

TABLE 5b: NUMBER OF COUNTIES ACCORDING TO THE PERCENT OF WOMEN OBTAINING ABORTIONS OUTSIDE THEIR PLACE OF RESIDENCE*

Population Size	Number (Percent) of Counties**							
	100,000		100,000-500,000		500,000		TOTAL	
Percent of women obtaining abortions in Ontario, outside county of residence								
24%	4	(8)	8	(17)	2	(4)	14	(29)
25-49%	3	(6)	7	(14)			10	(20)
50-74%	4	(8)	4	(8)			8	(16)
75-100%	15	(31)	1	(2)	1	(2)	17	(35)
	26	(53)	20	(41)	3	(6)	49	(100%)

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* NOTE: Excluded are women who obtained abortions outside of Ontario or in freestanding clinics in Ontario since data were not available.

** For the purposes of these tables, grouped as one county are: Leeds and Grenville; Prescott or Russell; Stormont, Dundas and Glengary; Sudbury District and the Regional Municipality of Sudbury; and Metropolitan Toronto.

TABLE 6: NUMBER OF COUNTIES WHERE MORE THAN 50 PERCENT OF WOMEN GO OUTSIDE THEIR PLACE OF RESIDENCE FOR ABORTIONS ACCORDING TO THE AVAILABILITY OF THERAPEUTIC ABORTION COMMITTEES.

Number of Therapeutic Abortion Committees in County	Number (Percent) of Counties
0	5 (20)
1	11 (44)
2	7 (28)
3	2 (8)
	25 (100)

FIGURES

FIGURE 1: COUNTIES WHERE OVER 50% OF WOMEN OBTAINING ABORTIONS GO OUTSIDE PLACE OF RESIDENCE

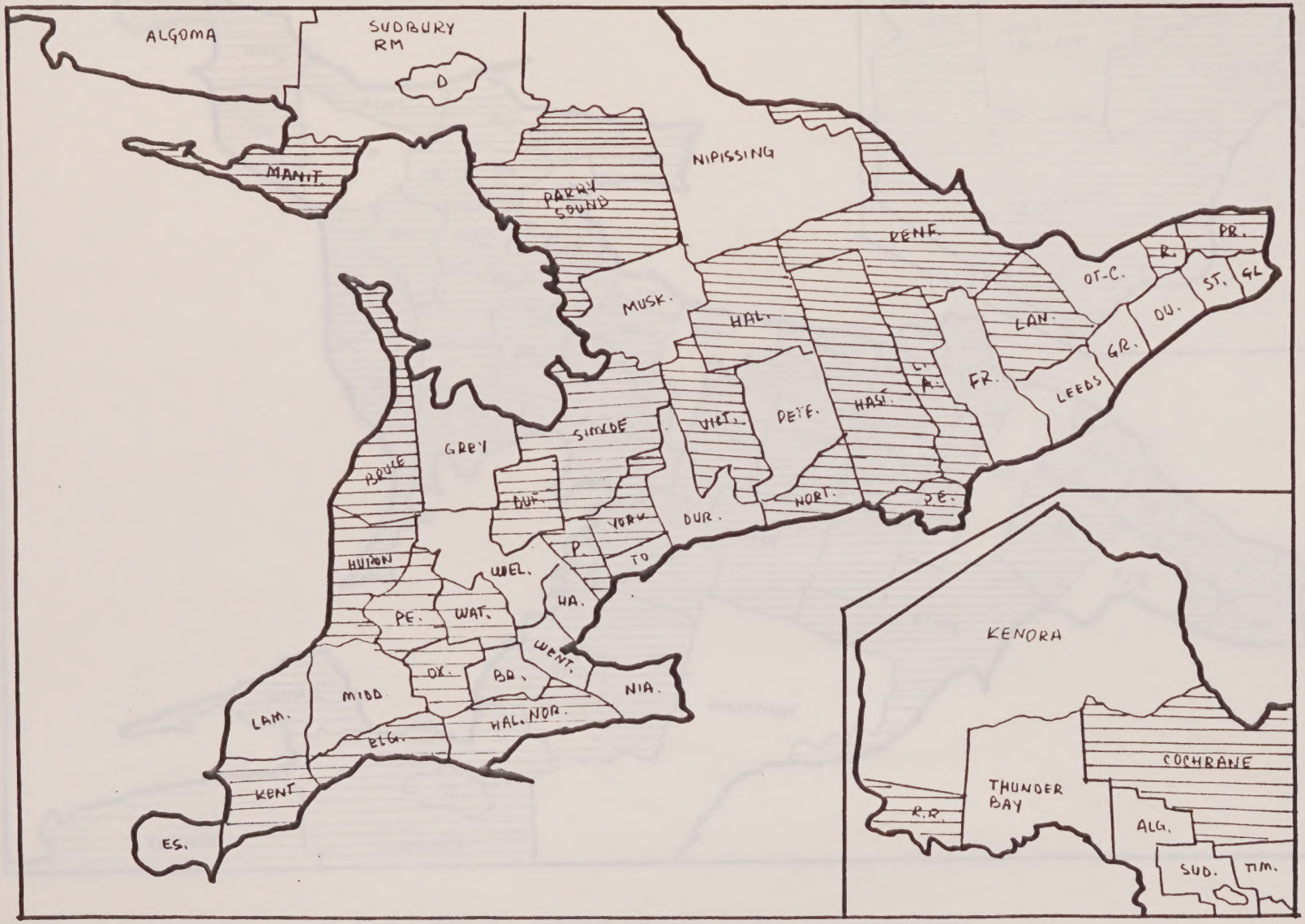

FIGURE 2. COUNTIES WHERE WOMEN CANNOT OBTAIN SECOND TRIMESTER ABORTIONS